Post-Ablation Follow-up Form

PMT FORM SELECTION: POST-ABLATION 180 DAY FOLLOW UP FORM	**Legend: Elements in bold are required**		
Patient ID:			
Date of most recent clinical follow-up (EP clinic or discharge date) (MM/DD/YYYY):	____/_____/_____	**Patient alive?**	O Yes O No
Adverse events:	O Yes O No (if yes, check all that apply): ❑ Air embolus ❑ Atrioesophageal Fistula ❑ AV Fistula ❑ Death ❑ Deep Venous Thrombosis ❑ Hematoma ❑ Hemopericardium ❑ Hypotension	❑ Myocardial Infarction ❑ Phrenic Nerve Injury ❑ Pseudoaneurysm ❑ PV stenosis ❑ Retroperitoneal Bleed ❑ Stroke ❑ Tamponade ❑ Cardiac tamponade or pericardiocentesis within 30 days post ablation ❑ Transfusion ❑ Transient Ischemic Attack	
Rehospitalization for complications:	O Yes O No	**If yes, enter date (MM/DD/YYYY):** ____/_____/_____	
Arrhythmia-related hospitalizations:	O Yes O No	**If yes, enter date (MM/DD/YYYY):** ____/_____/_____	
Cardioversion:	O Yes O No	**If yes, enter date (MM/DD/YYYY):** ____/_____/_____	
Recurrence of Clinical Arrhythmia (Electrocardiographically/EGM confirmed):	O Yes O No	**Since their last visit, has there been a change in medical therapy?**	O Yes O No
Antiarrhythmic Discontinuation:	O Yes O No	**If yes, enter date (MM/DD/YYYY):** ____/_____/_____	
Is the patient currently taking any of the following cardiac medications?	O Yes O No (if yes is selected, check all that apply): ❑ ACE-I ❑ Aldosterone Antagonist ❑ Angiotensin Receptor Blocker ❑ Beta Blockers	❑ Digoxin ❑ Diuretic ❑ Nondihydropyridine (CCB) ❑ Statin	
Is the patient currently on antiarrhythmic drug therapy?	O Yes O No (if yes is selected, check all that apply): ❑ Amiodarone ❑ Disopyramide ❑ Dofetilide ❑ Dronedarone ❑ Flecainide ❑ Lidocaine	❑ Mexilitine ❑ Procainamide ❑ Propafenone ❑ Quinidine ❑ Ranolazine ❑ Sotalol	

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Is the patient currently on anticoagulation therapy?	O Yes O No (if yes is selected, check all that apply): ❑ Aspirin ❑ Aggrenox ❑ Apixaban ❑ Clopidogrel ❑ Dabigatran	❑ Edoxaban ❑ Rivaroxaban ❑ Prasugrel ❑ Ticagrelor ❑ Warfarin If no: Date of discontinuation: _____ Reason for discontinuation (check all that apply) o Major bleeding event o Minor bleeding event o Risk of bleeding o CHA_2DS_2-VASc Score < 2 o Switch to antiplatelet agent
Repeat Ablation (Clinical Arrhythmia):	O Yes O No	**If yes, enter date (MM/DD/YYYY):** ____/_____/_____
Sinus rhythm maintained after ablation [new elements]	O Yes O No	**Estimated time patient was in sinus rhythm post ablation _____ days**
How was maintenance of sinus rhythm determined	❑ Symptoms ❑ Resting office ECG ❑ 24 hour monitoring ❑ 7 day monitoring ❑ 21 day monitoring ❑ 30 day monitoring ❑ Implanted loop recorder ❑ intracardiac lead ❑ UTD/ND	
Symptoms of Recurrent Arrhythmia:	O Yes O No	

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